HELPFUL QUESTIONS FOR FAMILIES TO ASK INSURANCE COMPANIES ABOUT COVERAGE OF EARLY INTERVENTION SERVICES

1. Is referral from a primary care physician (PCP) necessary? If so, who pays for the examination/assessment needed to make the referral?

2. Is a written medical diagnosis or prescription from the physician required in order for payment to be authorized? (Note: most of the time, the answer will be "yes." Although there is a diagnosis code – called an "IC-9 code" – for developmental delay, many insurance companies will not recognize it as a diagnosis they will payment for treatment.)

3. If the requested service is covered in the family's policy, when is pre-authorization required? Who needs to make the request (service provider, patient or either)?

4. Does the insurance company cover services that are delivered at home or in the community rather than at a medical facility? What are the restrictions for these types of services?

5. What is the insurance company's policy on covering pre-existing conditions?

6. Is the specific condition of the child covered in the policy? What conditions are <u>not</u> covered in the insurance policy? Are services such as speech therapy, physical therapy, occupational therapy and developmental intervention covered services when a child has a developmental delay or disability? Another way to word the question: will the insurance company pay for services if the condition is chronic as opposed to acute?

7. If the answer to one of the above questions was yes, here are some follow-up questions:

    a. Who is authorized to provide the service? (Ex: physical therapist only or also a physical therapist assistant?)
    b. Is the annual number of allowable visits for each discipline or for all disciplines combined? For example, does "60 visits per year" mean 1) 60 visits <u>each</u> for physical therapy, occupational therapy and speech therapy, or 2) 60 visits total for all therapies combined, or 3) 60 <u>consecutive visits</u> (this typically refers to acute conditions, not developmental conditions)?

8. Is there a maximum lifetime benefit of the policy? If so, what is the amount?

9. Is there a current list of providers for the requested service(s) available from the insurance company? Is there an out-of-network benefit? If so, what are the procedures, deductibles, co-pays, annual number of visits and/or annual amount the insurance company will pay, etc.? (Parents are advised to call the providers from the list to confirm that they are still network providers for the family's insurance company).

10. Who is the person at the insurance company with whom you are speaking and what department or area does s/he represent? Document date and time of call.

Additional Notes

- *In general, the two main entities the family has to work with to maximize insurance usage are the doctor and the insurance company.*
- *Even if a family receives information over the phone from their insurance company that some First Steps services may be covered, that does not constitute a guarantee of payment. Insurance companies reserve the right to review an insurance claim when they actually receive it.*